# Prior Authorization Program
# Frequently Asked Questions

**Updated June 1, 2006**

## Program Changes

**What is the official start date to call KePRO?**

| | |
|---|---|
| May 22 | Outpatient Psychiatric |
| June 5 | Inpatient/Intensive Rehabilitation, Home Health, DME (including orthotics), Outpatient Rehabilitation (excluding outpatient psychiatric services), and EPSDT |
| June 12 | Inpatient Acute, Inpatient Psychiatric, Non-Emergent scans |
| June 19 | Specialized behavioral health (treatment foster care case management, residential psychiatric treatment, intensive in-home), home and community based waivers |

**Methods for Submitting Prior Authorization Requests**

- Internet / iEXCHANGE™
  http://dmas.kepro.org
- Telephonic
  1-888-VAPAUTH (827-2884)
  804-622-8900 (local)
- Via Fax
  1-877-OKBYFAX (652-9329)
- Via U.S. Mail
  2810 N. Parham Road, Suite 305
  Richmond, VA 23294

**What happens if I need to modify or extend a current PA?**

Since we are transitioning to a new system of prior authorization (PA), most requests received to modify an existing PA will be assigned a new PA number. This will be a one-time change. All PAs you have currently will continue in effect until you request a change or an extension to that PA. This will affect Mental Health, Home Health, Rehabilitation and Waiver service providers.

**Will the new prior authorization fax forms be downloadable and will providers have the ability to type on them like they currently do on the DMAS 351? Some of our providers will be faxing theirs and this would be so helpful.**

The fax forms are available on the KePRO website at http://dmas.kepro.org/default.aspx?page=forms. They are available in both a pdf. format and an electronic format that providers can type directly into, download and save for future use.

Please note: KePRO will honor the submission of old forms up to July 31, 2006. Starting August 1, 2006, KePRO will reject requests that are submitted with old forms.

**How will providers receive responses to PA requests?**

KePRO will accept requests for PA via iEXCHANGE (direct data entry through the web), fax, mail, or phone. The preferred method of submission for requesting PA is through iEXCHANGE.

Responses to requests submitted via iEXCHANGE will be available to providers on iEXCHANGE. If you choose to phone or fax your request to KePRO, your response will come back in the form of a fax.

**If phoning in requests, can we call in multiple cases per phone call or is there a limit of 2 per call as there was with WVMI?**

There is no limit and we envision being able to have reviewers schedule times with providers if there are volume and logistical reasons to do so.

## Services

**Please clarify whether or not concurrent reviews have to be completed and for what specific setting.**

Acute Med/Surg services, which are paid on a DRG basis, will not require concurrent review.

Inpatient Psych, inpatient rehabilitation, comprehensive outpatient rehab facility (CORF), residential psychiatric treatment, treatment foster care case management, and intensive in-home services, which are based on the per diem payment methodology, will continue to require concurrent review.

**In relation to the Acute Med/Surg admissions, the policy states that if the request is received untimely, (not received within 24 hours of admission) the entire admission is denied. Would DMAS be willing to consider relaxing the requirement for a transition period of time?**

DMAS will relax the requirement of timely submission for those requests received at KePRO through July 31, 2006. Starting August 1, 2006, timely submission for requests will again be applied and determinations will be made based on timeliness.

**Has the timeframe for submission of requests for acute inpatient admissions changed?**

Providers will continue to have 24 hours (i.e., next business day) in which to obtain a prior authorization for all admissions. This includes planned admissions. Additionally, as with the current process, providers may submit retro-authorizations to KePRO when notified of a patient's retroactive eligibility for Virginia Medicaid coverage.

**If the provider/physician in an outpatient setting wants a scan (MRI/PET, etc) stat, how am I going to obtain a PA right away? Are there guidelines set up for emergency situations other than a patient going to the emergency room?**

Clinical approval is available when the review is completed by the review nurse. PAs are batched each night and returned to KePRO each morning.

Urgent scans that are performed prior to obtaining preauthorization must be retrospectively authorized. The definition of an urgent scan is when the ordering physician identifies an urgent need to have a scan performed the same day as seen by the physician. The physician sends the patient immediately to the hospital or outpatient facility to have the scan performed. The ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization within one business day of the scan being performed. When contacting KePRO to perform retrospective review, notify KePRO that the scan was performed on an urgent basis and provide the necessary information and medical appropriateness indications for the scan that has already been performed.

**For outpatient PT, OT, ST, we are currently given a PA number for an Evaluation and 2 visits. Will that continue?**

No. For Outpatient Rehab and for Home Health, every visit over the service limit will require PA and must satisfy the criteria for approval.

**Patient is admitted, but does not meet criteria on the 1st day but does on the second day (request submitted timely). Will the PA be given for the whole stay or just approval for the second day forward?**

The current process will still be in effect, i.e., the approved admission date will be the date that the InterQual criteria is satisfied, no dates prior to this will be authorized.

**Observation visits: Medicare allows 72 hours (using InterQual criteria). What does Medicaid criteria require and what is the (number of days, hours) maximum time before a PA is required?**

As noted in the DMAS Hospital Manual, Chapter IV, a hospital may bill for observation bed services for up to 23 hours. A patient stay of 24 hours or more will require inpatient pre-certification where applicable.

**Patient presents in the ER, then admitted from ER to for inpatient care, and subsequently discharged. Facility has been calling WVMI to get PA number, but received notice that services denied for not needing a PA. Please explain.**

If the stay was outpatient or observation the provider would not be required to obtain a PA. If the patient were admitted and discharged on same date a PA would be required. DMAS does require the ER to bill on the inpatient stay if ER visits results in a patient being admitted.

**Can you convert an existing PA from ambulatory care to an inpatient stay? Can we do an update or do we have to submit a new request? Patient has a status change going from ambulatory care to inpatient stay.**

Ambulatory care does not require a PA. A PA should be requested when the client is admitted. When the status changes to an admission the provider must call within 24 hours or the next business day of the admission date.

**Patient comes in with ascites, is determined to need a liver transplant and is directly admitted to the hospital. Hospital received PA for the ascites visit. Do we use this PA number for the transplant procedure and the inpatient stay or do we need 3 different PA numbers?**

The transplant procedure itself (except corneal transplants) is required to be reviewed by the DMAS Medical Support Unit. This team will give a PA number for the transplant procedure, which is used by the physician doing the transplant.

The inpatient hospital admission requires a separate PA from the PA given by the DMAS Medical Support Unit. This hospital PA for transplants is the same for any other inpatient hospitalization. Therefore, two PA number are required: one for the transplant procedure and one for the hospital admission for the procedure when it is preformed. Any other related admissions will also require a PA.

**Patient presents to medical facility with chest pain and gets PA number. However, it was determined that the presenting diagnosis is not medical but psychiatric. This facility does not handle psych so the patient is discharged and admitted to one of the medical facilities that covers psych. Admission was denied but overturned on appeal. WVMI states cannot overturn medical to psychiatric admission but the reverse is true. Explain.**

Acute medical/surgical admissions are paid on a DRG methodology. Only the date of admission is reviewed. If the information satisfies the InterQual criteria the admission date is approved. The claim must reflect a med/surg primary diagnosis code for this authorization to be valid and reimbursement to be made.

Psychiatric admissions are paid on a concurrent review basis. Each day is reviewed for medical necessity. The claim must reflect a primary diagnosis code within the ICD- 9 cm range of 290 thru 319 for this authorization to be valid and reimbursement to be made.

KePRO will be able to change a psych admission to an acute admission because all of the days have been reviewed. However, they cannot change an acute admission to a psych admission because only the admit date is reviewed. This is the current process and will remain the same.

**What to do when hospital providers contact KePRO retrospectively and request that a review be changed from a psychiatric stay to an acute stay?**

KePRO **may** do as requested because psychiatric stays are reviewed concurrently, therefore the change would be valid.

**What to do when hospital providers contact KePRO retrospectively and request that the admission be changed from an acute stay to a psychiatric stay?**

KePRO **may not** do as requested because with acute stays only the day of admission has been reviewed and psychiatric stays require concurrent review, therefore all of the days that the provider would be requesting would not have been reviewed. **Exception:** TDO days only may be changed from acute to psychiatric.

**Currently we are submitting for PAs on patients with Medicare or other primary insurance without evidence of exhaustion or cancellation of this coverage to WVMI. Are we now to only file after we know that Medicaid has become primary?**

No PA is required unless Medicare benefits are exhausted. If Medicare denies the requested stay or benefits are exhausted, the provider may submit a preauthorization request for retrospective review, along with the explanation of benefits (EOB) of denial. This request must be submitted to the DMAS PA contractor within ~30 days of the Medicare denial

## iEXCHANGE

**Are there any plans in place or in the works to have the ability for InterQual and iEXCHANGE interface so providers do not have to enter all of the same information?**

There is an interface currently available that will allow a hospital UM system to copy information directly into iEXCHANGE. The interface is available for the Inpatient setting only. MEDecision does have a contact person for this component of their business. The contact person we were given is Matt Waltrich and his telephone number is 1-610-540-0202.

**If using iEXCHANGE, can we cut and paste from InterQual the 'SI' (Severity of Illness) info and the 'IS' (Intensity of Service) info into both boxes?**

KePRO would need to understand the case management system the provider is using. However, the review process involves reviewing the clinical information submitted by the requesting provider against InterQual criteria. Therefore, it is imperative that the information submitted be sufficient to justify the clinical necessity of the services being requested. It is not sufficient to simply state that the case meets the InterQual criteria.

**In iEXCHANGE, clinical information is requested and I will not have the information until the patient has been evaluated. What do I do?**

KePRO will need complete clinical information in order to complete a review. However, if the clinical information is not submitted with the initial entry into iEXCHANGE, KePRO will notify the provider that there is insufficient information to process the request.

Clinical information must be submitted within the required timeliness of submission requirements per the notice from KePRO that there is insufficient information to process the request.

**How do providers customize the drop down boxes under iEXCHANGE?**

Instructions are available on the KePRO website at for setting up your iEXCHANGE account and customizing your providers, frequently used ICD 9 Codes and frequently used diagnosis codes.
http://dmas.kepro.org/documents/iexchange/3%20iEXCHANGE%20Admin%20Training.pdf

**How long are records kept in iEXCHANGE? Will we be able look at all previous PAs that have been entered for a patient for years or so?**

iEXCHANGE and CarePlanner are clinical review tools and facilitate the acquisition of PAs. Once the PA information is submitted and entered into iEXCHANGE it will be retained and available to providers for six years. There will not be a transfer of PA data from WVMI to KePRO.

**Is there a limit to how many diagnosis/disciplines can be listed for one PA in a Home Health setting? Can I use multiple diagnoses for more than one provider?**

The system will allow for the submission of up to five diagnoses per PA. Each PA is specific to one recipient and provider combination. Each PA in VaMMIS can include up to 18 procedures or services. Presently, iEXCHANGE can capture five requested procedures or services in a dedicated field in Section 2 of the data entry screen. The remaining procedures or services can be entered as text in the *Additional Comments* field.

**Do I have to know the ICD codes or can I just put in the diagnosis?**

iEXCHANGE contains a search option that will help you identify the ICD 9 code based on the description you type in. There is also a feature that allows the provider to populate a drop down menu with the most commonly used ICD 9 codes and descriptions for their practice.

**Can the ICD codes be pre-loaded? By whom?**

ICD 9 codes are already loaded in the iEXCHANGE system and are updated annually. The facility may type the code into the diagnosis box which will then be validated by iEXCHANGE. The facility user may also create a drop down list of frequently used Dx codes.

**Is there a limit to the number of ICD codes that can be populated in iEXCHANGE?**

The ability to add to the drop down list is unlimited. Please see the answer to question 4 if this question pertains to the number of codes that can be submitted per PA.

**Why is there a 'length of stay' required for the inpatient submission?**

This is related to Inpatient Psych and Rehab services which are based on a per diem methodology. This does not apply to Inpatient Acute Med/Surg, which is based on DRGs.

For Inpatient Acute Med/Surg, enter 1, as we only review the admit date information for criteria review. For Intensive Rehab and Inpatient Psych, enter the number of days requested for the entire stay.

**For the outpatient PA submission, where the units are entered in iEXCHANGE, are the units for hours or days?**

This is specific to the program you are requesting services for. This information can be found in the Medicaid manuals for the program for which you are requesting PA.

## Training

**Will additional training sessions be available for providers?**

Additional pre-recorded WebEx trainings will be available in June. Keep checking the KePRO website http://dmas.kepro.org or the DMAS website at www.dmas.virginia.gov - look at the "What's New" section under Prior Authorization.

## Other Questions

**What happens if I do not have the provider number and they are a new provider?**

Prior Authorizations are linked to the provider through the provider number. Recipients are free to choose a provider as long as the rendering provider participates with Medicaid. If the provider does not have a number, they need to enroll with the DMAS provider enrollment unit. If you have any enrollment questions, please contact:

First Health Services - PEU
PO Box 26803
Richmond, VA 23261-6803
Phone: 1-888-829-5373 (in state toll-free) 1-804-270-5105 (local)
Fax: 1-804-270-7027

KePRO receives weekly updates from First Health for the provider files.

**Is there somewhere I can find out if a provider is a DMAS approved provider and how often does DMAS update this?**

Yes, DMAS operates a provider search system on the DMAS website. This is available at www.dmas.virginia.gov/provider_search.ASP

KePRO also receives weekly updates from First Health for the provider files.

**Is there somewhere I can find out recipient eligibility and how often does DMAS update this?**

Yes. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

## Updates

Please look for information in the coming weeks about training to use the iEXCHANGE® system, and for detailed program information. The most up-to-date information will be posted on the DMAS Website at this website address: http://www.dmas.virginia.gov/pr-prior_authorization.htm and on the KePRO website address http://dmas.kepro.org

Should you have any questions regarding the prior authorization program, please send your inquiries via e-mail to PAUR06@dmas.virginia.gov.